SEATTLE AREA PLUMBING & PIPEFITTING INDUSTRY HEALTH TRUST

MAILING ADDRESS
P.O. Box 88970
Tukwila, WA 98138

PHYSICAL ADDRESS
5200 Southcenter Blvd, Ste #205
Tukwila, WA 98188

PHONE: (206) 694-1374
TOLL FREE: (888) 406-3246
FAX: (206) 788-8398

Time Loss/Weekly Disability
Application Form

- **HOW TO FILE A CLAIM FOR DISABILITY BENEFITS**
  PART I. Must be completed by the employee indicating dates of disability.
  PART II. Must be completed by the physician verifying dates of total disability.

PART I — Employee's Statement

1. Employee's Name: (Please Print) Married ☐ Single ☐ Divorced ☐

   _____ _____
   First M.I. Last Phone No.

2. Address: _____ _____
   Number Street E-mail

   _____
   City State Zip

3. Employee's Social Security Number _____ Home Local Union No._____

4. Employer's Name _____ Date last employed _____

5. Date First Unable to Work:

   _____ Hour _____ □ a.m.
   (Date) □ p.m.

6. Date Returned to Work:

   _____
   (Date)

IF CLAIM WAS DUE TO AN ACCIDENT, PLEASE COMPLETE QUESTIONS 7 AND 8

7. Date of Accident _____ Where _____

   How _____

8. Did accident occur while on a job for an employer? YES ☐ NO ☐

I hereby certify that the foregoing statements, including any accompanying statements, are true, correct and complete to the best of my knowledge, and hereby further authorize my Provider of Services to furnish and disclose all facts concerning my physical condition that are within their knowledge.

Employee's Signature _____ **Date** _____

◂ PLEASE HAVE YOUR PHYSICIAN COMPLETE PART II ON REVERSE SIDE ▸

Seattle Area Plumbing & Pipefitting Industry Health Trust

Time Loss - Part II

PART II Attending Physician's Statement

1. Patient's Name _____ Date of Birth _____

2. Diagnosis _____

3. Date of first treatment _____

4. Date of hospital admit (if applicable) _____

5. Date of surgery (if applicable) _____

6. Date of most recent treatment _____ 20 _____

7. Patient has been totally disabled from _____ 20 _____ through _____ 20 _____

8. When should patient be able to return to work? _____ 20 _____

9. Remarks _____

_____

_____
Physician's Name (Please Print)

_____
Street Address

_____
City State Zip Code

Telephone _____ Fax _____ E-mail _____

_____
Physician's Signature Degree Date

SEATTLE AREA PLUMBING & PIPEFITTING INDUSTRY HEALTH TRUST

DISABILITY BENEFIT ELECTRONIC FUND TRANSFER (EFT) REQUEST

COMPLETE THIS SECTION IF YOU WANT DISABILITY PAYMENTS DEPOSTED DIRECTLY INTO AN ELIGIBLE CHECKINGS OR SAVINGS ACCOUNT.

If you do not elect to have your benefits deposited to your bank account, you will receive a check in the mail.

I REQUEST MY WEEKLY BENEFIT BE SENT TO MY BANK (OR OTHER FINANCIAL INSTITUTION SHOWN BELOW) FOR ELECTRONIC FUNDS TRANSFERS.

I. NAME: _____ SOC. SEC. #: _____
(Please Print) (last 4 digits only)

ADDRESS _____

_____
(City) (State) (Zip)

TELEPHONE NUMBER (_____)_____ Email Addr:_____

If this is a NEW address, please check here ___

II: FINANCIAL INSTITUTION
Name _____Phone Number(____)_____

Branch Mailing Address _____

_____
(City) (State) (Zip)

ACCOUNT NUMBER (please check **only** one) **We can NOT direct deposit to a debit card**. Please provide your checking or savings account information only.

_____ Checking Account: My account number is _____
***Attach a "voided" check**
Please provide the 9 digit Bank Routing Number: _____

"OR"

_____ Savings Account: My account number is:_____
***Attach a deposit slip, if available**
Please provide the 9-digit Bank Routing Number: _____

As benefit payments become payable, I authorize the Administrative Office to pay by directing the electronic transfer of funds, to the order of the above named financial institution for credit to my account. I authorize said financial institution to refund an amount equal to any payment, which becomes due after my death that has been credited to my account or to charge the account accordingly. In addition, in the event of an incorrect amount or entry, I authorize the Administrative Office to reverse this transaction. I reserve the right to cancel this authorization and direction by giving written notice to the Administrative Office.

I will notify the Administrative Office when I change my permanent residence and advise at that time if payments are to continue to be sent to the financial institution named above.

Signature _____ Date _____